

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03040

3072

Items 1.7 R11wG226 3-24-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>St. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicville</u> 18X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Galvert Co. Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Johnson</u> First <u>Alvey</u> Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SINGLE <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12, 1901</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Thomas</u>		14. MOTHER'S MAIDEN NAME <u>May Buckler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>420.1</u>	
17. INFORMANT <u>Leonard Alvey</u> Address <u>Mechanicville MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> DUE TO <u>Coronary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Had a cerebral hemorrhage 1 yr ago</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been up and shuttling, etc. well. Found dead</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Month, Day, Year <u>6/40 3/10-1958</u> Hour <u>6:40</u> a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u>		20f. City or town <u>Prince Frederick</u> (County) <u>Calvert</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		22d. LOCATION (City, town, or county) <u>Morganza</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. CLARKE MATTINGLEY</u>		24a. REC'D BY REGISTRAR <u>W. CLARKE MATTINGLEY</u>	
ADDRESS <u>LEONARDTOWN, MARYLAND</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAR 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3073

## CERTIFICATE OF DEATH

Reg. Dist. No.

03038

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>				c. LENGTH OF STAY IN 1b <b>74 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Abraham</b> Middle <b>Brown</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/12/84</b>	
9. AGE (In years last birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None-Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>Joseph Brown</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Raviea Maxwell Owings md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>and arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 28</b> , 19 <b>58</b> , to <b>March 30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 30</b> , 19 <b>58</b> , and that death occurred at <b>10:30AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Huntingtown, Maryland</b> DATE SIGNED <b>3/30/58</b>							
ACTUAL SIGNATURE <b>[Signature]</b>				PHYSICIAN'S NAME (Type) <b>Dr. George J. Weems</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>4-2-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>mt. hope</b>		22d. LOCATION (City, town, or county) (State) <b>Sunderland md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. J. Sewell B. Fred</b>				24a. REC'D BY REGISTRAR <b>DATE APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White	
DATE OF DEATH Jan 15 1958		PLACE OF DEATH Home		CITY Baltimore		STATE Maryland	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION Teacher		EDUCATION High School	
DATE OF BIRTH Jan 1 1913		PLACE OF BIRTH Maryland		CITY Baltimore		STATE Maryland	
FATHER'S NAME John Doe		MOTHER'S NAME Jane Doe		FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker	
FATHER'S DATE OF BIRTH Jan 1 1880		MOTHER'S DATE OF BIRTH Jan 1 1885		FATHER'S PLACE OF BIRTH Maryland		MOTHER'S PLACE OF BIRTH Maryland	
FATHER'S CITY Baltimore		MOTHER'S CITY Baltimore		FATHER'S STATE Maryland		MOTHER'S STATE Maryland	
FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker		FATHER'S EDUCATION High School		MOTHER'S EDUCATION High School	
FATHER'S DATE OF DEATH Jan 1 1950		MOTHER'S DATE OF DEATH Jan 1 1955		FATHER'S PLACE OF DEATH Maryland		MOTHER'S PLACE OF DEATH Maryland	
FATHER'S CITY Baltimore		MOTHER'S CITY Baltimore		FATHER'S STATE Maryland		MOTHER'S STATE Maryland	
FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker		FATHER'S EDUCATION High School		MOTHER'S EDUCATION High School	

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BUREAU V. S.

PR 7 1958

12. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 15th day of January, 1958.

WITNESSED BY ME, the Registrar of Deaths, Baltimore, Maryland, on the 15th day of January, 1958.

\_\_\_\_\_  
Registrar of Deaths, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G227 4-2-58 et

3074

## CERTIFICATE OF DEATH

Reg. Dist. No.

03039

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>17 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert Co., Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Murray Claggett</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16-1894</b>
9. AGE (In years last birthday) <b>63 6/4</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Charles Claggett</b>		14. MOTHER'S MAIDEN NAME <b>Katie Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Son-Hames Claggett</b>		Address <b>Sunderland Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive C. V. R. disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>2-10</b> , 19 <b>58</b> , to <b>3/21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/21</b> , 19 <b>58</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>[Signature]</b> ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. George Weems</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-23-58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>mt. hope</b>		22d. LOCATION (City, town, or county) (State) <b>Sunderland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.E. Sewell</b>		ADDRESS <b>Pn. Fred. Md</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



RECEIVED

MAR 26 1958

BUREAU V. 5.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 1 M1MG226 3-17-58 et  
3075  
CERTIFICATE OF DEATH

03041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Holland Point Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Gamble</u> Last <u>Gamble</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6, 18</u> yrs. <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ALA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Jane Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Boris White Pr. Fred, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart disease</u> (c) <u>Hypertension CVD</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>sub 15</u> , 19 <u>58</u> , to <u>March 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>58</u> , and that death occurred at <u>630 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. G. VILLARREAL</u>		DATE SIGNED <u>3/4/58</u>	
PHYSICIAN'S NAME (Type) <u>R. G. VILLARREAL</u>		ADDRESS (Street, city or town, state) <u>St. Bernard</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-7-58</u>		22b. DATE THEREOF <u>3-7-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carrolls</u>		22d. LOCATION (City, town, or county) (State) <u>Barstow Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell Pr. Fred, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Paul Sewell</u>			

**BUREAU V. S.**

MAR 13 1958

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

03042

3076

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>Prince Frederick</i>			
3. NAME OF DECEASED (Type or print) <i>Edith</i> First <i>King</i> Middle <i>King</i> Last				4. DATE OF DEATH Month <i>3</i> Day <i>8</i> Year <i>1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-12-1898</i>	9. AGE (In years last birthday) <i>59</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Calvert, Md.</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Gantt</i>				14. MOTHER'S MAIDEN NAME <i>Clara Lyles</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <i>Florence Saunders, Pr. Fred.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chenue</i> <i>260X</i> DUE TO <i>Cerebral hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes Mellitus</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Jan</i> , 1958, to <i>March</i> , 1958, that I last saw the deceased alive on <i>March 8</i> , 1958, and that death occurred at <i>10:30</i> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. E. Villard</i> M.D.				ADDRESS (Street, city or town, state) <i>St. Thomas</i>			
DATE SIGNED <i>3/10</i>							
PHYSICIAN'S NAME (Type) <i>R. E. VILLARD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3-11-58</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Brook's</i>		22d. LOCATION (City, town, or county) (State) <i>Mutual, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell - Pr. Fred, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Al. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Page 11

BUREAU V. 8

MAR 13 1938

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03043

3977

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake Beach</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chesapeake Beach,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>J. C.</b> Last <b>Klein</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 20, 1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Mdse.</b>	11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Phillip Klein</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Lindorfer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-32-1168</b>	
17. INFORMANT <b>Phillip Klein, Chesapeake Beach, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10 July, 1955</b> , to <b>5 Mar, 1958</b> , that I last saw the deceased alive on <b>1 Mar, 1958</b> , and that death occurred at <b>10 p. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. J. Weems</b>		ADDRESS (Street, city or town, state) <b>Huntingtown, Md</b>	
DATE SIGNED <b>3/6/58</b>			
PHYSICIAN'S NAME (Type) <b>G. J. Weems, Huntingtown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Hutchins</b>		ADDRESS <b>Owings, Md.</b>	24a. REC'D BY REGISTRAR <b>DATE MAR 10 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Albee</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 10 1938

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1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 3078 CERTIFICATE OF DEATH

03044

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Cabot</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cabot Nursing Home</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> OR TOWN <u>08X-2</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Cornie</u> (First) (Middle) (Last) <u>Mc Cauley</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 18</u> 19 <u>58</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 9, 1883</u>	9. AGE last birthday <u>74</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charles Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel B. Curren</u>			14. MOTHER'S MAIDEN NAME <u>Stella Marks</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-44-0789</u>		17. INFORMANT & ADDRESS <u>Samuel C. Mc Cauley Captain Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
421.4 IMMEDIATE CAUSE (A) <u>Hypertensive Cardiac Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Vascular Hardening?</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Tuberculosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 28, 1957</u> , to <u>March 18, 1958</u> , that I last saw the deceased alive on <u>March 18, 1958</u> , and that death occurred at <u>10:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Page J. H.</u>		M.D. <u>PRINCE FREDERICK</u>		DATE SIGNED <u>3/18/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>3/20/58</u>		NAME OF CEMETERY OR CREMATORY <u>Southern Heights</u>			
24. REC'D BY REGISTRAR <u>MAR 21 '58</u>		REGISTRAR'S SIGNATURE <u>W. H. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Michael Mc Lepata Md</u>			
DATE		ADDRESS					



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03045

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lesbury</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lesbury</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Arthur J Moran</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR GERARD MORAN</u>				4. DATE OF DEATH Month Day Year <u>Mar. 4, 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4/1898</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mech Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J Moran</u>				14. MOTHER'S MAIDEN NAME <u>Agnes F. Cordoni</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>216-10-2380</u>		17. INFORMANT Address <u>Margaret Moran wife</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>G. J. Weems</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>G. J. WEEMS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>3/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. D. Harkness &amp; Son - Mutual, Inc.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 6 58</u>		24b. REGISTRAR'S SIGNATURE <u>G. J. Weems</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED LAST NAME FIRST MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF DEATH MONTH DAY YEAR	
PLACE OF DEATH STREET CITY STATE		TIME OF DEATH HOUR MINUTE	
OCCASION OF DEATH (Check one) <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unknown		CAUSE OF DEATH (Check one) <input type="checkbox"/> Heart <input type="checkbox"/> Lungs <input type="checkbox"/> Brain <input type="checkbox"/> Stomach <input type="checkbox"/> Liver <input type="checkbox"/> Kidneys <input type="checkbox"/> Spleen <input type="checkbox"/> Pancreas <input type="checkbox"/> Gallbladder <input type="checkbox"/> Intestines <input type="checkbox"/> Urinary <input type="checkbox"/> Reproductive <input type="checkbox"/> Endocrine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Nervous <input type="checkbox"/> Circulatory <input type="checkbox"/> Respiratory <input type="checkbox"/> Digestive <input type="checkbox"/> Excretory <input type="checkbox"/> Other	
MANNER OF DEATH (Check one) <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unknown		PLACE OF DEATH STREET CITY STATE	
TIME OF DEATH HOUR MINUTE		DATE OF DEATH MONTH DAY YEAR	
NAME OF PHYSICIAN STREET CITY STATE		NAME OF MEDICAL EXAMINER STREET CITY STATE	
SIGNATURE OF PHYSICIAN (Print name) DATE		SIGNATURE OF MEDICAL EXAMINER (Print name) DATE	

BUREAU V. 8

MAR 6 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3080

## CERTIFICATE OF DEATH

Reg. Dist. No.

03046

1. PLACE OF DEATH o. COUNTY <u>Cabret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Cabret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>26 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>B. Poehler</u> Last <u>—</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1909</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Filling Station</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Clarence Poehler</u>				14. MOTHER'S MAIDEN NAME <u>Margaret May</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-10-125</u>		17. INFORMANT <u>Julia Poehler - Prince Frederick, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>March 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Mar 10</u> , 19 <u>58</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page C Jett</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>3/11/58</u>			
PHYSICIAN'S NAME (Type) <u>PAGE C JETT MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Barstow - Cabret Co - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackness &amp; Son - Annapolis, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3081

## CERTIFICATE OF DEATH

Reg. Dist. No. 03047

1. PLACE OF DEATH o. COUNTY <b>Calvert</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>03X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>				d. STREET ADDRESS <b>3012 Elizabeth Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Billie</b> Middle <b>Mae</b> Last <b>Ridgely</b>				4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 23, 1952</b>	
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>William J. Ridgely</b>				14. MOTHER'S MAIDEN NAME <b>Eva Mae Gott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. William Ridgely, 3012 Elizabeth Ave. Baltimore 30, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unbearable shock</b> <b>510.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Tore of heart following</b> DUE TO (c) <b>Removal of kidney &amp; liver</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>20</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>after 12 hrs pt lost some blood which was placed</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>by shock</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/2</b> , 19 <b>58</b> , to <b>3/5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/5</b> , 19 <b>58</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Owings, Maryland</b> DATE SIGNED <b>3/5/58</b>							
ACTUAL SIGNATURE <b>H. W. Ward</b> M.D. <b>Owings</b>				PHYSICIAN'S NAME (Type) <b>H. W. Ward, Owings, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Harmony Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Owings, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Hutchins</b>				ADDRESS <b>Owings, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 7 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. A. Hutchins</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 7 1959

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03048**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Calvert</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ches Beach</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ches Beach</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Margaret Lucile Stegney</u> First Middle Last				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>24</u> Year <u>1958</u>											
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>E</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan 9/58</u>		<b>9. AGE</b> (In years last birthday) yrs. <u>28</u>		<b>IF UNDER 1 YEAR</b> Months <u>2</u> Days <u>15</u>		<b>IF UNDER 24 HRS.</b> Hours <u>2</u> Min. <u>00</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) _____				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> _____			
<b>13. FATHER'S NAME</b> <u>Donald G. Smith</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha E. Stegney</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> _____				<b>17. INFORMANT</b> <u>Mother</u> Address _____							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Respiratory infection</u> <u>527.2</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO _____ (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Found dead in bed</u>												INTERVAL BETWEEN ONSET AND DEATH _____			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____											
<b>20c. TIME OF INJURY</b> Month <u>3</u> Day <u>24</u> Year <u>1958</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Howard</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>EXAMINER'S NAME (Type)</b> _____						<b>DATE SIGNED</b> <u>3/24/58</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> _____				<b>22b. DATE THEREOF</b> <u>3-22-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Edmonds</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Sunderland</u>				<b>(State)</b> <u>Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>P. E. Sewell</u>						<b>ADDRESS</b> <u>Ph. Fred Md</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Alfred</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Alfred</u>			
<b>DATE</b> <u>MAR 26 '58</u>						<b>2064203XV3</b>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR 25 1958

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG226 3-20-58 et

3083

## CERTIFICATE OF DEATH

Reg. Dist. No.

03049

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert Co., Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>L</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 27 1872</b>	9. AGE (In years last birthday) <b>85 1/2</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>58</b>	IF UNDER 24 HRS. Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lemuel Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Mary Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Son--Edward Thomas Owings</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Jaundice of Feet + Uremia</b> <b>4442 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.V.R. disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>Indefinite</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Walked in snow barefoot.</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>11:30 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Page Jett</b> M.D.				ADDRESS (Street, city or town, state) <b>Prince Frederick</b> DATE SIGNED <b>3/6/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Page Jett</b>							
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>3-9-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>		22d. LOCATION (City, town, or county) (State) <b>Sunderland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.E. Sewell</b> ADDRESS <b>Prince Frederick</b>				24a. REC'D BY REGISTRAR <b>MAR 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text, possibly "John Doe"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>	
<p>3. AGE                  [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH                  [Faint text, possibly "1910"]</p>	
<p>5. PLACE OF BIRTH                  [Faint text, possibly "Baltimore, Md"]</p>		<p>6. OCCUPATION                  [Faint text, possibly "Teacher"]</p>	
<p>7. MARITAL STATUS                  [Faint text, possibly "Married"]</p>		<p>8. DATE OF MARRIAGE                  [Faint text, possibly "1935"]</p>	
<p>9. NAME OF SPouse                  [Faint text, possibly "Jane Doe"]</p>		<p>10. DATE OF DEATH                  [Faint text, possibly "March 10, 1958"]</p>	
<p>11. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>		<p>12. CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>	
<p>13. MEDICAL HISTORY                  [Faint text, possibly "Hypertension"]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Faint signature]</p>	
<p>15. SIGNATURE OF REGISTRAR                  [Faint signature]</p>		<p>16. DATE OF REGISTRATION                  [Faint text, possibly "March 13, 1958"]</p>	

MAR 13 1958

BURKAY K. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3084

CERTIFICATE OF DEATH

03050

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dwight</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dwight</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Mary E. Ward</i>		4. DATE OF DEATH Month <i>3</i> Day <i>4</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 23, 1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm. Handesty</i>		14. MOTHER'S MAIDEN NAME <i>Ella Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mr. Joseph L. Lumsden</i>		Address <i>Dwight Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i> <i>153.8</i> DUE TO <i>Cerebral vascular cerebral disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary atherosclerosis</i> (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>18 mo</i> <i>1 hr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1, 1958</i> to <i>March 4, 1958</i> , that I last saw the deceased alive on <i>March 4, 1958</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. W. Ward</i>		ADDRESS (Street, city or town, state) <i>Dwight Md</i>	
PHYSICIAN'S NAME (Type) <i>H. W. WARD</i>		DATE SIGNED <i>3/4/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-6-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Friendship</i>	22d. LOCATION (City, town, or county) (State) <i>Friendship Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. Hutchins</i>		ADDRESS <i>Dwight Md</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	
DATE <i>MAR 7 '58</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 7 1958

RECEIVED